

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-05-9127.M2

NOTICE OF INDEPENDENT REVIEW DECISION

July 18, 2005

Requestor

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Respondent

Liberty Mutual Insurance Company  
ATTN: Melissa Rodriguez  
FAX#: (512) 231-0210

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-05-1947-01  
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Anesthesiology, by the American Board of Anesthesiology Inc, licensed by the Texas State Board of Medical Examiners (TSBME) in 1989, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This male patient injured his low back and right gluteal region in a work related event. He has been treated with therapy, medications, trigger point injections and Botox chemodenervation.

Requested Service(s)

One visit of 8 Botox chemodenervation injections with Electromyogram guidance

Decision

It is determined that there is no medical necessity for the one visit of 8 Botox chemodenervation injections with Electromyogram guidance

Rationale/Basis for Decision

This patient was injured in \_\_\_ and treated for a bulging disc with good resolution of symptoms. Diagnostic reports indicated a grade I spondylolistheses at L5-S1. Medical record documentation indicates the symptoms he is now experiencing in his right gluteal region is likely related to the pre-injury/pre-existing spondylolistheses and not his injury. Medical record documentation also indicates he has received Botox chemodenervation injections in the past; however, there is no peer reviewed studies to validate the use of this type of treatment for this patient's type for complaint. Therefore, the one visit of 8 Botox chemodenervation injections with electromyogram guidance is not medically necessary to treat this patient's medical condition.

This decision by the IRO is deemed to be a TWCC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c)).

**If disputing other prospective medical necessity (preauthorization ) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm  
Attachment

cc: Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 18th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Attachment**

**Information Submitted to TMF for TWCC Review**

**Patient Name:** \_\_\_\_

**TWCC ID #:** M2-05-1947-01

**Information Submitted by Requestor:**

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**Information Submitted by Respondent:**

- Progress Notes
- Case Notes for Liberty Mutual